INGENIX®

Montana Facilities
WC Fee Schedules follow-up

March 2008

DRAFT

Agenda

Introductions

1. Review of overall goals
2. Review of MHA recommendations
   - A. Recommendations with general agreement [p.4-6]
   - B. Recommendations that may not be feasible [p.7-8]
   - C. Recommendations meriting further discussion [p.9]
3. Moving from Conceptual Agreement to Implementation
   - Inpatient Calculations & Payments
   - Outpatient Calculations & Payments
4. ASC Outpatient Calculations & Payments
5. Potential Methodology Options for Implantables, Ambulance Services, & other Reimbursement Carveouts

1. Review of Roles and goals

The Ingenix role

Our contract with DLI calls for Ingenix to help facilitate any rule-making process.

Our mission is to help DLI and stakeholders understand and build a consensus for workers' compensation facility reimbursement.

In this presentation, Ingenix has summarized MHA's recommendations along with DLI's perspective to help foster a basis for further discussion.

Jerry Keck and/or staff to outline DLI's goals.

2. Review of MHA recommendations

To leave as much time as possible for topics needing further discussion, these are recommendations that DLI will look favorably at adopting and should not require much/any additional discussion.

- MS-DRGs are an appropriate array of DRGs to properly group workers' compensation hospital admissions
- Hospitals suggest the Department specify that all services provided during an uninterrupted patient encounter be included in the inpatient stay.
- Hospitals recommend that the Department limit its transfer payment policy to transfers between two acute care hospitals. In those cases the Department should follow Montana Medicaid's transfer payment formula.

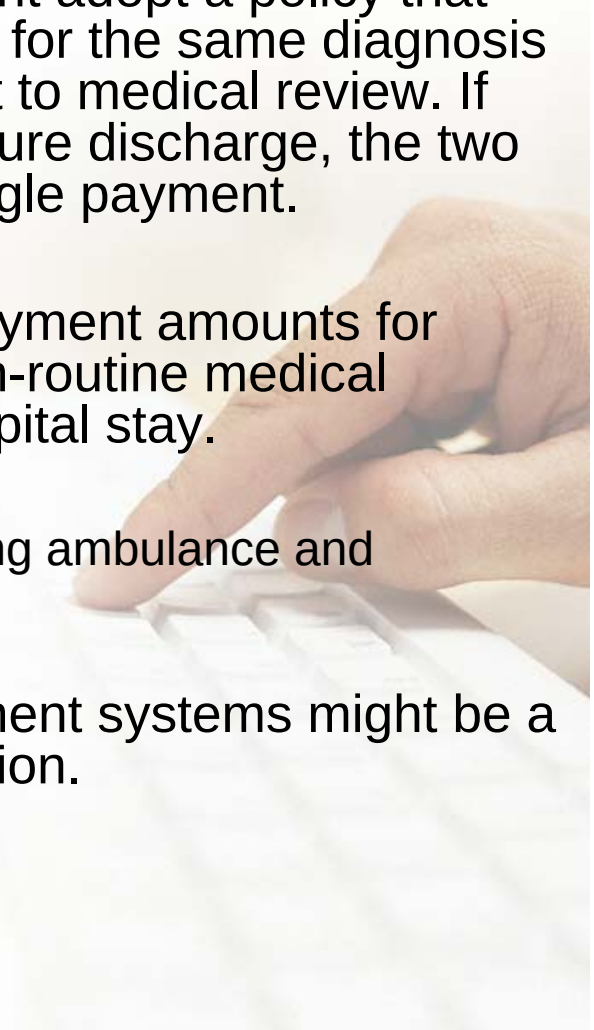
2 A. MHA general agreements

- Hospitals recommend that the Department adopt a policy that readmissions to inpatient care that occur for the same diagnosis within two weeks of discharge be subject to medical review. If the case is determined to involve premature discharge, the two claims should be combined to yield a single payment.

- Hospital payments should not include payment amounts for ambulance, air ambulance and other non-routine medical transportation that occurs during the hospital stay.

  - DLI will look at developing or implementing ambulance and transportation rules separately

- …. hospitals believe the fixed price payment systems might be a better alternative for hospital rate regulation.



2 A. MHA general agreements (continued)

For this reason we recommend that the Department include in the new regulations a requirement that medical necessity review, claim audits and other administrative procedures be conducted on a post-payment basis.

- DLI sees this favorably, but is reviewing with payers whether there are any unintended consequences of adopting such a provision.

2 B. MHA Recommendations that may not be feasible

MHA recommended:

Additional review is needed to evaluate Medicare's relative weights for the Workers' Comp APCs.

Data is not readily available to conduct such a review. Very few states make outpatient all-payer databases available. They are expensive to access, and may not contain sufficient workers' compensation claims for analysis.

Existing Montana data is numerically insufficient for a reliable study

While such a review could be modeled from limited data, it is likely to be both time consuming and expensive to undertake.

2 B. MHA Recommendations that may not be feasible

The Department will need to develop its own relative weights for the DRGs to assure an appropriate payment amount is determined.

- Potential issues
  - Costly and/or time consuming to do so
  - Methodology development may cause problems
  - Overall system amounts won't change, but distribution within MS-DRGs may change
  - On-going maintenance issues

2 C. Recommendations meriting further discussion

The rehabilitation DRG is not an appropriate basis for substantial rehabilitation services beyond a few days. When these cases arise, Medicare utilizes a separate DRG payment method for inpatient rehabilitation services. Rather than adopt a much more complicated payment method for these services, hospitals recommend the Department establish the payment rate rehabilitation unit services at 80% of the hospital charges.

- DLI is generally in agreement in principle, but is investigating with payers to see if there are unintended consequences of such a decision.

3. From Concept to Implementation: Overall objectives

DLI has had three objectives through this methodology review process:

- Reduce inequities in the system so patients get appropriate care in appropriate settings
- Eliminate bottlenecks and other inefficiencies. Reducing inefficiency while maintaining system integrity should reduce costs.
- Reduce system costs while preserving access to care for injured workers as well as balancing the needs of stakeholders

3. From Concept to Implementation: MHA recommendation on inpatient payment

MHA recommendations:

- … a base price equal to 200% of Medicare to model the proposed (inpatient) payment system.

- Hospitals recommend that the Department establish an outlier trim point at 1 standard deviation from the arithmetical mean charges for each DRG .

- The Department should specify that the payment amount be 80% of the charges above the outlier trim point.

These three items are related since each affect the overall cost to the workers' compensation system.

3. From Concept to Implementation: Inpatient payment & trim point relationship with outlier

On a system-wide basis, two things affect the overall system expenditures for hospital inpatient:

- Baserate
- Outlier trigger point and outlier payment

If an outlier trigger point is some function of the normal payment amount, then the baserate affects where outliers are triggered.

System Cost = Routine payments + outlier payments

3. From Concept to Implementation: Medicare outlier trim point

- Medicare's formula for calculating outliers and payments is complicated
- Under Medicare, an outlier triggers around $50,000- $75,000 in charges (this varies by hospital and other factors).
- In the State Fund data, there were 13 cases with billed charges > $75,000. There were 288 cases, so outliers represented about 4.5% of the cases.
- FYI: The average inpatient charge was $30,704.

3. From Concept to Implementation: Statistical approach to trigger point

- MHA's recommendation is to set the trigger point at one standard deviation of the arithmetic mean charge.
  - This means a sizable number of claims are likely to trigger outlier status
  - The more cases falling to outlier status, the lower the baserate.
  - State Fund data does not contain enough data for most DRGs to provide an accurate trigger calculation. The Ingenix all-payer database does, but creates several additional complications.

3. From Concept to Implementation: Inpatient payment data from a variety of states

DLI looked at State Fund data as well as other sources for comparative Medicare and commercial payments.

- A Milliman Inc. study in 2006 in Washington found Medicare underpaid Washington hospitals by approximately 15% on an overall basis

- A Pennsylvania Health Care Cost Containment study found that in 2005, Pennsylvania hospitals were underpaid by Medicare by approximately 16 percent.

3. From Concept to Implementation: State review for percentage paid

- Data in the Milliman study indicated that commercial payers in Washington were paying approximately 150% of Medicare.
- In the State Fund data, there were four very expensive cases totaling more than $1 million in charges.
- If these outlier cases are removed from the overall calculation, the State Fund payments were approximately 193% to Medicare (Based on 2005 payment amounts).
- If outlier cases are included on a dollar for dollar basis, the State Fund payments were approximately 155% to Medicare. (Based on 2005 payment amounts)
- Dollar-for-dollar = Based on data limitations, it is impossible to determine what Medicare's outlier amount would have been, so the actual payment is added to both sides of the calculation.

3. From Concept to Implementation: How to establish outlier trigger amounts

DLI has expressed a desire to keep outlier rules as simple and clear as possible in order to reduce confusion between hospitals and payers.

There are three commonly used methods of setting an outlier trigger:

1. Triggers are established by DRG by some statistical measure. (MHA recommendation)
2. Triggers are established as some multiplier of the normal payment amount, i.e. where charges > 5 x DRG payment
3. Triggers are established as some amount over the DRG payment, i.e. charges > $100,000 + DRG payment

3. From Concept to Implementation: DLI request to Ingenix for Inpatient Modeling

At DLI's request:

- Ingenix modeled several approaches to find a "best fit"
- The model used various static triggers
- DLI expressed a desire to reduce outlier charges to costs and then paying some percentage above cost.
- A goal was to keep the number of outliers triggered to approximately the same number of cases.
- Another goal was to keep the methodology as clear as possible, so that implementation can go smoothly

3. From Concept to Implementation: Inpatient Modeling for outliers

Using this scenario, Ingenix:

- Used 155% of the national 2008 Medicare baserate or $7,694. This percentage derives from State Fund data and is consistent with the Washington study. With no wage indexing, this is approximately 10% above what Montana hospitals would typically receive from Medicare, or about 165% of Medicare for most Montana hospitals.

- Selected 65% of the charge above the trigger as the outlier payment. If a typical hospital's facility-wide RCC is 0.50, then 0.65 represents cost plus 15 percent of the charge

- Modeled various threshold triggers that produced roughly the same number of outlier cases at roughly the same expenditure.

Under this scenario, a trigger of DRG Payment + $50,000 produced 17 outlier cases compared ~13.

3. From Concept to Implementation: Inpatient Modeling results

Ingenix estimated:

- Paid amounts in existing data totaled $5,742,000.
- The modeled amount is $5,314,732

The median difference (modeled paid – actual paid) was -$206

Caveats:

- The 2008 base rate is based on MS-DRGs, and the existing data is DRGs, V.24. There are likely to be some differences
- The 2005 outlier experience, and outlier location, may not mirror experience going forward.

3. From Concept to Implementation: Need for more data

A difficulty in estimating workers' compensation hospital payments compared with commercial payers is the lack of solid, reliable data for comparative purposes.

Accordingly, DLI is considering adopting a rule requiring covered hospitals to submit, from their previous fiscal year, the following:

- Number of Medicare claims
- Total Medicare billed for those claims
- Total Medicare reimbursement received from Medicare for those claims
- Number of commercial payer claims (but not self-pay)
- Total billed for those claims
- Total reimbursed for those claims
- Number of workers' compensation claims
- Total billed for those claims
- Total reimbursed for those claims

3. From Concept to Implementation: Outpatient outlier

MHA:

The Department should adopt an outlier policy similar to that recommended for the inpatient DRG proposal

DLI would request MHA suggest a specific outpatient outlier policy.

3. From Concept to Implementation: Outpatient Discount codes

MHA:

Hospitals agree with the Department's proposal to ignore T and Q status codes and maintain status code N.

DLI is reconsidering the discount issue for T status codes. This does not appear to significantly affect hospitals, but has considerable impact for ASCs.

DLI is still proposing to ignore the Q status code and keep N status codes. This is as previously outlined.

Further discussion about this issue follows in the carveout section

3. From Concept to Implementation: APC payments

MHA:

…the APC payment method, using a base price equal to 250% of the Medicare base price.

DLI is considering:

- For APC-status items, implementing 165% to Medicare, which was approximately the effective rate found in the analysis of the Liberty Northwest data. This would be a $105.10 baserate versus a 2008 Medicare national baserate of $63.70.
- For fee schedule items and other non-APC services, the payment would be 75 percent of billed charges, which is approximately what existing data shows is being paid.

4. Outpatient & ASCs

The following represents MAASC's proposed fee schedule for Montana Worker's Compensation:

- 10% off billed charges except for implants (L8699) which will be paid at 100% of the billed charge (we can further define what constitutes an implant).
- CCI Edits will be used to determine bundling and unbundling of charges.
- Work Comp will not reduce reimbursement for 2nd, 3rd, 4th, etc. procedures.
- Carved out reimbursement for "pain pumps" and "radio frequency ablation wands" to be paid at 100% of the billed charge (we can create our own codes for these items).

4. ASC proposal

DLI agrees:

- CCI Edits will be used to determine bundling and unbundling of charges.

MAASC:

- Carved out reimbursement for “pain pumps” and “radio frequency ablation wands” to be paid at 100% of the billed charge (we can create our own codes for these items).

DLI is considering following hospital model, that is, cost plus 15 percent over cost. If the item is not invoiced, then DLI would used non-listed code rule and payment would be 75 percent of charges

4. ASC discussion, payments

MAASC:

- 10% off billed charges except for implants (L8699) which will be paid at 100% of the billed charge (we can further define what constitutes an implant).

DLI is considering following hospital outpatient model and paying ASCs at 65% of the hospital rate. The proposed hospital rate is $105.10 which puts the ASC rate at $68.32. The current 2008 Medicare non-blended rate would be $41.40.

5. Carveouts: Outpatient discounts

Following the last meetings, DLI/Ingenix learned that ASC billing may already contain discounts for secondary procedures. Some ASCs may be adjusting their charges to reflect a discount schedule. As the result, the ASC paid/discount analysis may be based on discounted charges. This affects overall workers' comp system expenditure calculations.

Approximately 3-4% of the hospital outpatient data contains T status codes, but approximately 35% of the ASC data has a T status.

DLI's initial response is to implement the 50% discount for secondary codes; however, DLI is inviting ASCs to conduct their own analysis and help DLI determine the impact of such a decision.

5. Methodology Options: Implantables

DLI recognizes that in some situations, more expensive implantables may be called for than normally allowed in a Medicare environment. Accordingly, DLI is considering a rule such as this:

Where a more expensive implantable device is appropriate, hospitals may seek additional reimbursement beyond normal payment. Where a single device cost exceeds $10,000 for inpatient service or $5,000 for outpatient service, hospitals are to be reimbursed at cost plus 15 percent. Where a separate payment is made, the implantable charge is excluded from any calculation for an outlier payment.

DLI would invite comments as to whether this a reasonable policy and where the cost thresholds ought to be established.

5. Methodology Options: Ambulance & Others

There are a number of medical service arenas where Medicare has developed specialized reimbursement mechanisms.

Where practical, DLI will adopt the Medicare specialized rules for such areas as Ambulance services.

Where these additional rules become needed, DLI's general principle will be to set the payment rate at 165% of the current national Medicare rate.

This principle does not apply to inpatient rehabilitation as discussed earlier.

